STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005080	A. BUILDING: _____ B. WING _____	C 02/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST MARGARET HEALTH - DYER	24 JOLIET ST DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00192503 Unsubstantiated: lack of sufficient evidence Date: 2/17/16 Facility Number: 005080 Franciscan St. Margaret Health-Dyer is in compliance with 410 IAC 15-1.5-4, Medical record services and 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: cjl 02/29/16	S 000		